NOTICE OF PUBLIC WORKSHOP
MEETING MINUTES

NOTICE IS HEREBY GIVEN; the Office for Consumer Health Assistance will hold a workshop to consider amendments to Nevada Administrative Code (NAC) Chapter 439B relating to disputes between third-party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19 (NRS 439B.700-NRS439B.760).

The workshop was conducted via TEAMS Meeting on Tuesday December 14, 2021:

The workshop was conducted in accordance with NRS 241.020, Nevada's Open Meeting Law.

AGENDA

1. Introduction of workshop process.

   Carrie Embree opened the public workshop at 1:02 pm.

   Carrie Embree stated okay well, I think we'll go ahead and get started. For those of you who don't know me, I am Carrie Embree, The Governor's Consumer Health Advocate with the Office for Consumer Health Assistance also known as OCHA. And with that, we just welcome all of you today. I'm glad you're here.

   We are going to go ahead and get started with the workshop and with that in mind. I'm going to go right into the agenda. So, the first agenda item is just an introduction of the workshop process. I would like to let you know as many of you may already know, but in case you don't that a small business impact questionnaire was completed. That was done by the end of September to the first few weeks in October. You can find the results of that questionnaire on Office for Consumer Health Assistance website. You can also find it on the Aging and Disability Services Division website. And, I understand the new federal law, The No Surprises Act, that will be going into effect here very soon. January 1st, 2022, and I have received some questions and I know some of you may also have questions about The No Surprises Act. However, this meeting today is specific to this public workshop regarding amendments to the

Nevada Administrative Code Chapter 4.390. With that in mind, I will not be answering questions today regarding The No Surprises Act. However, if you do have questions, you're very welcome to send me an email and I just want you to know that we can always send me an email with your questions. Also, for today the chat is disabled. If you would like to make a comment you can just raise your hand in the teams; and when your name is called, please state your name and spell your name for the record of the workshop. Moving on to the next agenda item number 2. This workshop is for public comment to consider amendments to Nevada administrative code Chapter 439 B relating to disputes between 3rd parties and insurers and out of network providers overpayments as medically necessary emergency services and this is in LCD file number R101-19.

2. Public comment on proposed amendments to Nevada Administrative Code (NAC) Chapter 439B relating to disputes between third-party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19 (NRS 439B.700-NRS 439B.760).

   Carrie Embree started the public comment with stating the workshop would be moving on to the next agenda item number 2. This workshop is for public comment to consider amendments to Nevada administrative code Chapter 439 B relating to disputes between 3rd parties and insurers and out of network providers overpayments as medically necessary emergency services and this is in LCD file number R101-19. And with that, we will move on to public comment and so, if any of you would like to make public comment if you just raise your hand and I'll call your name.

   Katie Ryan stated hi there everyone. Thank you, Madam hearing officer, so for the record my name is Katie Ryan. K. A. T. I. E. R. Y. A. N. I am the system director of Nevada Government Relations for Dignity Health Saint Rose, Dominican. We have provided the state with 3 comment letters. One dated September 27th, 2019. Another dated February 4th, 2020, and then another dated today in reaction to the proposed regulations. One of the main concerns we continue to have with operationalization of this law is just the difficulty of keeping track of a pairs' participation, either due to the election process for some plans or the difficulty in determining whether or not an insurance plan was sold in Nevada. In Texas, their division of insurance has been able to mandate a code that's put on Texas purchase plans and we still think that that could happen here in Nevada. We understand that this is a small percentage of the plans but even that small percentage would be helpful for our staff.

   And then since we met last in 2020 as you mentioned the No Surprises Act was passed by Congress and now that adds to the additional operationalization issues that we are under. We really hope that there's going to be some sort of cross-law that helps us figure out which law we need to follow for each patient situation and very grateful to the hearing officer for helping us schedule a meeting with OCHA and DOI tomorrow to discuss but just wanted to say that we appreciate any help that we can get in this matter. And then just wanted to go on the record again for thanking you for speaking with us multiple times on the phone to share our concerns

and ask questions and that concludes my comments. Please let me know if you have any questions.

James Wadhams stated I don't want to be repetitive, and I appreciate that this is a workshop, and your identification of the federal No Surprises Act is both comforting and disconcerting in the context of trying to develop a state regulation of a process that actually predated the Federal Act. And yet now as the evolution of the federal proposed regulation is evolving, it seems to complicate the inter-relationship and therefore the either overlapping areas of application or those areas where the federal act may apply after the state act terminates and I understand that we can't address anything in the Federal Act, but from a purely legal standpoint, I think it's going to be critical for patients and providers, hospitals, and physicians to have some understanding of flexibility from the regulator and a good faith attempt to comply as opposed to running the risk of ignoring the federal law and trying to apply the state law as to creative problems so I know this is a workshop and maybe that can be a an area for further consideration. Secondly in in reviewing the most recent iteration, I apologize I should have said, on behalf of Hospital Association, we had some general comments about the regulation itself that I think would be worthy to restate and I'll try to be brief because there's only a couple of them. I think your evolution has been otherwise very helpful.

The definition of a claim that is the amount because that triggers the differential treatment of the under 5000 and over 5000. That definition could be done by regulation and would be appropriate if the agency is interested in doing so of identifying those elements of a claim or the amount of a claim. Is it the amount in dispute? Is it the amount that was originally claimed in the invoice? Avoiding that subtlety could minimize issues both that trigger above 5000 and below 5000 and maybe even avoid unnecessary arbitration issues. I think we have raised in in the past as difficulty under Section 2 subsections C and D. In particular, where the request requires the type and specialty of each health care practitioner. I think it would be it would be worthwhile for the for the agency to consider limiting that to the, I'll call it, captain of the ship. Whoever the person primarily responsible for that treatment, maybe because in a typical or even a common episode of an emergency service there could be several different practitioners, and with the differentiation we have today in terms of credentialing, that becomes a very detailed and perhaps very extensive listing of the type and specialty of each health care practitioner.

The second element is at Subsection D right below it and it's the type of third party that provides the coverage. If it's identified as one of the self-insured groups that might be relatively easy for example a Labor Trust Fund. On the other hand, it could be identified because of the card presented or the information presented it could appear to be an insurance company. And yet, they would be acting as a third-party administrator or administrative service contract for a self-insured employer that either did or did not opt in. In that subtlety is one that's going to complicate protecting the patients, as well as the response of the provider, and the ability to contact the payer. I think I have one more on the content.

There is a provision in Section 3 Subsection 4 which states very simply an arbitrator selected pursuant to subsection 2 may request from the third party any additional information the arbitrator deems necessary. I believe we have raised this in the past. I don't believe there is statutory authority for the arbitrator to request information. Yeah, it is the reverse that. So, the payer and the provider can provide any information they deem necessary. The arbitrator otherwise must do the baseball arbitration choice and pick one or the other without any differentiation. And with that I think that summarizes some of the prior comments that we would like to have addressed. Again, I simply want to restate. We appreciate that this is a workshop and that overlap and interaction with the federal No Surprises Act. I think is going to be problematic. Both for the agency trying to enforce this and both of payers and providers trying to respond. Thank you.

Carrie Embree stated A couple of things. One, I forgot to say this, and to help provide some insight. OCHA is working with CMS regarding the No Surprises Act, so there is something that is happening. So, in relation to how this does impact the current regulations we're working on and how it impacts Nevada, we are working with CMS. That's still in progress and we're not done with it yet. So, we just would like all of you to be aware of that. And also, regarding the arbitrator to request additional information, we've had situations where we may receive information but it's not complete information or the information isn't clear, we simply want to be able to reach back out and ask for that clarification and/or if it's the documentation to support what have you and that's what that is for specifically. We were advised that we because we are the state entity that they bring the arbitration that we do have authority to do that, so but in all due respect, Jim to your comment about the baseball arbitration, and OCHA that is what we follow, and we don't just go ask for information that is not necessary. It really is so that information we do receive that it's completely clear and understand what we are in receipt of.

Jessica Ferrato stated hi good afternoon, Carrie and Charles, appreciate your time today. For the record, I am Jessica Ferrato here today on behalf of ASAP, the American College of emergency physicians. Just a reminder. I know it's been a few years since we've talked publicly about these regulations, but I represent all emergency physicians here in Nevada. We have over a 500 in the state. Covering a wide range of issues for patients, including emergency medical services, public health, and safety and disaster preparedness and response. I want to thank you guys for all the work that you've continued to do on this issue. I just want to echo comments made by previous speakers in wanting to collaborate with what's happening at the federal level to make sure we have some clarification on how the federal law aligns with these state regulations and again I communicated this at various workshops in the past and through the legislative process, but my clients still have significant concerns over the lack of notification through billing on whether a patient is covered under this law. Providers cannot determine whether or not a claim is covered under AB469 or not. Only the payer has that information and so it's really putting a burden on the process, and I know on your office potentially because it's hard for us to tell whether or not a claim is appropriate for arbitration or not, and I know that those are being filed with your office and then denied. So, from our standpoint, we'd like to see some type of notification on the claim or the bill so that providers know which patients are covered and which are not and not only from the provider standpoint, but from a patient transparency standpoint. We think that this

would strengthen the law significantly. So just a few things I'd like to add again. Thank you guys so much for your ability to take in information from us and keep this conversation open.

3. Public Comment.

   No public comment was made

The proposed changes will amend Chapter 439B of the Nevada Administrative Code relating to disputes between third-party insurers and out-of-network providers over payment of medically necessary emergency services in LCB File No. R101-19 (NRS 439B.700-NRS 439B.760).

The proposed regulations will provide for:

- Required content of an arbitration request for a disputed claim of less than $5,000.
- The review and approval of the request by the Department.
- The Department to provide the out-of-network provider and third-party insurer with a written list of five randomly selected employees of the State who are qualified to arbitrate the dispute.
- The selection of an arbitrator and the procedure for the arbitration.
- The requirement for a dispute about a claim in the amount of $5,000 or more, for the out-ofnetwork provider to request a list of five randomly selected arbitrators from the American Arbitration Association or JAMS.
- The procedure for making and withdrawing an election by an entity or organization not otherwise subject to provisions of the law governing the resolution of disputes between a third-party insurer and an out-of-network provider of health care over payment for medically necessary emergency services to elect to have those provisions apply to the entity or organization.
- A third-party insurer that provides coverage to residents of the State to annually submit to the Department certain information for the purpose of compiling a report.

Members of the public may make oral comments at this meeting. Persons wishing to submit written testimony or documentary evidence may submit the material to Carrie Embree at: Aging and Disability Services Division

3416 Goni Road

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We are pleased to make reasonable accommodations for members of the public who have disabilities and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Rebecca Ortiz at (775) 684-5956 as soon as possible and at least one business day in advance of the meeting. If you wish, you may e-mail her at rebeccaortiz@adsd.nv.gov.

Supporting materials for this meeting are available at 3416 Goni Road, D-132, Carson City, NV 89706, or by contacting Rebecca Ortiz at (775) 684-5956, or by e-mail: rebeccaortiz@adsd.nv.gov

A copy of the regulations and workshop information can also be found on-line by going to: Nevada Aging and Disability Services Division:

http://dhhs.nv.gov/Programs/CHA/ http://adsd.nv.gov/

and

Aging & Disability Services (nv.gov)

A copy of this notice has been posted at the following locations:

1. Aging and Disability Services Division, Carson City Office, 3416 Goni Road, Suite D-132, Carson City, NV 89706
2. Aging and Disability Services Division, Las Vegas Office, 1860 East Sahara Ave., Las Vegas, NV 89104
3. Aging and Disability Services Division, Reno Office, 9670 Gateway Drive, Suite 200, Reno, NV 89521
4. Nevada State Library and Archives, 100 North Stewart Street, Carson City, NV 89706
5. Sierra Regional Center, 605 South 21st Street, Reno, NV 89431

Notice of this meeting is also posted on the Internet: https://ADSD.NV.gov, and https://notice.nv.gov and has been sent to the Legislative Counsel Bureau.

Copies may be obtained in person, by mail, or by calling (775) 684-5956.

Per NRS 233B.064(2), upon adoption of any regulations, the agency, if requested to do so by an interested person, either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption and incorporate therein its reason for overruling the consideration urged against its adoption.